

No. 2
M-5-43
5-17-39
I X3667

FILED JAN 20 1944
Registration District No. **818**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State MO (b) County 17

(c) City or town ST LOUIS **926**
(If outside city or town limits, write "RURAL")

(d) Street No. 2013 N. 13th St B
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME EPHIM MAMCHUR

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4
year 1944 hour 7 minute P.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUG 1 1888
(Month) (Day) (Year)

Immediate cause of death Cerebro of the liver
Chronic Interstitial Nephritis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Thomas F Callahan (M. D. or other) _____
Address Deputy Coroner Date signed 1-7-44

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

55 5 3 hr. _____ min.

9. Birthplace Shumber Valinski Russia 6
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Varele Mamchur

13. Birthplace Russia 6
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant COND RAT KONEYS KY

(b) Address 3717 LINCOLN

17. (a) BURIAL (b) Date thereof 1-8-43
(Burial, cossation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNT HOPE CEMETERY

18. (a) Signature of funeral director CENTRAL UND CO

(b) Address 18 41 CASS AVE

19. (a) JAN 7 1944 (b) J. F. Brodeur
(Date received local registrar) (Registrar's signature)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed.....

John Agonosh
.....

Licensed Embalmer No. *3398*.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.